

**INDIANA WORKER'S COMPENSATION
FIRST REPORT OF EMPLOYEE INJURY, ILLNESS**

State Form 34401 (R9 / 3-01)

FOR WORKER'S COMPENSATION BOARD USE ONLY

Jurisdiction

Jurisdiction claim number

Process date

Please return completed form electronically by an approved EDI process.

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION					
Social Security number	Date of birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Occupation / Job title		NCCI class code
Name (last, first, middle)	Marital status <input type="checkbox"/> Unmarried <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown		Date hired	State of hire	Employee status
Address (number and street, city, state, ZIP code)			Hrs / Day	Days / Wk	Avg Wg / Wk
Telephone number (include area code)		Number of dependents	Wage Per \$ <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year <input type="checkbox"/> Other		
<input type="checkbox"/> Paid Day of Injury <input type="checkbox"/> Salary Continued					

EMPLOYER INFORMATION			
Name of employer City of West Lafayette	Employer ID#	SIC code	Insured report number
Address of employer (number and street, city, state, ZIP code) 609 W Navajo West Lafayette, IN 47906	Location number	Employer's location address (if different)	
	Telephone number (765) 775-5150		
Carrier / Administrator claim number			Report purpose code
Actual location of accident / exposure (if not on employer's premises)			

CARRIER / CLAIMS ADMINISTRATOR INFORMATION			
Name of claims administrator Accident Fund Insurance	Carrier federal ID number	Check if appropriate <input type="checkbox"/> Self Insurance	
Address of claims administrator (number and street, city, state, ZIP code) PO Box 40790, Lansing, MI 48901	<input checked="" type="checkbox"/> Insurance Carrier <input type="checkbox"/> Third Party Admin.	Policy / Self-insured number WCY6062275	
Telephone number (866) 206-5851		Policy period From 1/1/2010 To 1/1/2011	
Name of agent MBAH Insurance	Code number 5027		

OCCURRENCE / TREATMENT INFORMATION					
Date of Inj. / Exp.	Time of occurrence <input type="checkbox"/> AM <input type="checkbox"/> PM	Date employer notified	Type of injury / exposure		Type code
Last work date	Time workday began	Date disability began	Part of body		Part code
RTW date	Date of death	Injury / Exposure occurred on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of contact		Telephone number
Department or location where accident / exposure occurred			All equipment, materials, or chemicals involved in accident		
Specific activity engaged in during accident / exposure			Work process employee engaged in during accident / exposure		
How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.					
					Cause of injury code
Name of physician / health care provider					INITIAL TREATMENT <input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinic / Hospital <input type="checkbox"/> Emergency Care <input type="checkbox"/> Hospitalized > 24 Hours <input type="checkbox"/> Future Major Medical / Lost Time Anticipated
Name of witness		Telephone number	Date administrator notified		
Date prepared	Name of preparer	Title	Telephone number		

An employer's failure to report an occupational injury or illness may result in a \$50 fine (IC 22-3-4-13).